



# Automated Clearing House (ACH) New Business Request

## A. Business Information

Business Name
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## B. Contact Information

1. Contact Name		2. Daytime Telephone Number (include hyphens)	
3. Contact Address			
4. City	5. State/Province	6. Zip/Postal Code	7. Country
8. E-mail Address		9. Re-type E-mail Address	

## C. Premium Information

Initial Premium Payment Amount \$
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## D. Bank Information

1. Bank Account Type (At this time we do not accept funds from a savings account.)	CHECKING
2. Account Holder Name (Must match the name as it appears on the actual check.)	
3. Routing Number (First 9 digits found on the bottom left of the check.)	
4. Account Number (The number on the bottom right of the check.)	

## E. Authorization

I understand that by completing this form I am authorizing Aetna and/or Aetna's representatives to withdraw this FIRST INITIAL PAYMENT from my checking account. This is a one time authorization for the First month premium only.

I understand that this direct payment will be deducted from my checking account within 1 to 2 business days after notification of our group health plan approval. This approval will be sent to my agent by Aetna.

Sender's Name (Printed)	Sender's Signature
Date Signed (MM/DD/YYYY)	Contact Telephone Number

<b>For Internal Use Only</b>	PSUID	Confirmation Number
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